Health Anxiety and Hypochondriasis: The Patient's Perspective

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Abstract

This qualitative study using a social constructionist epistemology looked at seven individuals' experiences of health anxiety and hypochondriasis. Participants were recruited using advertisements on local public notice boards, word of mouth and a published newspaper interview. Participants self-identified as having health anxiety or hypochondria and ranged between 18-64 years of age. There were three male and four female participants. A thematic narrative analysis was undertaken. Common themes that were identified were: childhood attachment styles, trauma, personal experience with illness, the function of health anxiety, health anxiety developing into adulthood, stigma of being labelled a hypochondriac, participants' positioning of self and others, participants' views on their doctors and communication styles.

Also outlined were participants' recommendations for managing symptoms and coping with doctors' consultations. Implications include integrating attachment theories into therapy for health anxiety and working towards improving communication skills between medical doctors and health anxious and hypochondriacal patients.

Preface of Terms

The present study included interviewing people who self-identified as having health anxiety and/or hypochondria. Research that is discussed in the current study refers to health anxiety, hypochondria and/or somatization in the same way. These terms will now be defined for the present study as:

Table 1 - Health Anxiety
Health anxiety is a term differentiated from hypochondriasis, as it does not meet the full Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for hypochondriasis (as listed below). Health anxiety includes an individual's excessive worry about their health, stemming from beliefs that the person's physical integrity is threatened. Health anxiety is multifaceted and consists of distressing emotions (e.g. fear), physiological arousal (e.g. palpitations), thoughts and images of danger, and avoidant behaviours. Health anxiety ranges from mild and transient, to severe and chronic (Taylor & Asmundson, 2004).

Table 2 - Hypochondriasis	
A.	Preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.
B.	The preoccupation persists despite appropriate medical evaluation and reassurance.
C.	The belief in criterion A is not of delusional intensity (as in delusional disorder, somatic type) and is not restricted to circumscribed concern about appearance (as in body dysmorphic disorder).
D.	The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
E.	The duration of the disturbance is at least six months.
F.	The preoccupation is not better accounted for by generalized anxiety disorder, obsessive compulsive disorder, panic disorder, a major depressive episode, separation anxiety, or another somatoform disorder (American Psychiatric Association, 2000).

Table 3 - Somatization
Somatization is the conversion of psychosocial stressors into bodily symptoms. This involves the tendency to experience and communicate psychosocial stressors physically, through bodily symptoms.

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1. Hypochondria and Health Anxiety

Although the 'butt' of many jokes, hypochondria is no laughing matter! The costly and time consuming medical treatments of patients with hypochondria and high health anxiety are enormous. The impact is huge on our health care systems, with medically unexplained symptoms accounting for 25-50 percent of all primary care visits in the general population (Barsky, 2000). According to Taylor and Asmundson (2004), people with hypochondria make up to 26 percent of this population. Hardy, Warmbrodt & Chrisman (2001) argue that a higher percentage bracket of 25-75 percent of all primary care office visits involve somatic presentations.

This impact extends beyond primary care settings, as health anxious and hypochondriacal people pay more visits to general practitioners and specialists than other people (Barsky, 2000). They have more medical laboratory tests and surgical procedures (Barsky, Ettner, Horsky, & Bates, 2001), both of which place great economic burden on healthcare systems. People who have high health anxiety tend to have more sick days off work than average and are also more likely to be on disability benefits (Sternberg, 1999).

Often there is a stigmatized view in society of hypochondriacal, health anxious people. This is reflected in some of the labels often used in describing the hypochondriacal patient, for example, as the *'worried well'*. There are unspoken 'rules' about who is entitled to *'the sick role'* (Parsons, 1975). This is evident in statements such as: *'Don't take any notice of him, he's just being a hypochondriac'*. Who is, and who is not, deserving of the sick role can be seen as socially constructed (Gergen, 1985). Adoption of the sick role, which includes time off work and gaining care from others, is permissible only when the sickness or disability is genuine, well known, accepted by society, and is easily demonstrated (as in a cast for a broken arm) (Hyden & Brockmeier, 2008). The sick role requires the patient to cooperate in efforts to return themselves to good health if possible, and do all that they can (Henderson, 1974; Rapport & Wainwright, 2006). In contrast, the hypochondriacal and health anxious patient may not meet

the constructed criteria of this sick role. They may not have accepted, well known illnesses, and they appear not to be complying with their doctor's advice and reassurance. That is, health anxious patients often seek second opinions, and further reassurances (Maj, Akiskal, Mezzich & Okasha, 2005).

The sick role of entitlement is not the only socially constructed phenomenon. According to social constructionist epistemology (which forms the framework for this study), knowledge lies within the process of social interchange (Gergen, 1985). At the same time, reality is different for all of us. Our social reality is seen through our individual lenses, based on our own unique life experiences and understandings of the world (Berger & Luckman, 1966). Reality can be seen as socially constructed by, and between, the people who experience it, in the hypochondriac's case, construction often lies between doctor and patient interactions.

Constructs such as hypochondria are shaped by the historical, cultural, political, and social norms which operate within a context and time (Gergen, 1999). Hypochondria has been described as an *'ancient malady'* (Starcevic & Lipsitt, 2001), along with other labels. The names over time have changed, including 'hysteria', but the symptoms have remained the same. As society and language have been constructed over time, so have our meanings and understandings for the set of behaviours that are commonly referred to in Western society as hypochondria (hypochondriasis for the medical experts!). To learn more about the construct of hypochondria, we need to first look at the language and context of this malady in history, to be informed on how it is constructed and understood by ourselves and wider society today. Thus an outline of the changing conceptualization of hypochondria will now be given, starting with the actual language construct of *hysteria* in ancient Greece. This overview starts with discussion on hysteria, which, according to the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) definition, was the initial name for hypochondriasis (American Psychiatric Association, 2000).

2. Historical overview of Hypochondria

Hypochondria is rooted in language constructs and gender stereotypes from around 2AD. The womb (named *hystera*) was said to be the origin of *hysteria,* a medical illness that affected women. Hysteria was said to be characterized by a variety of physical symptoms at one time or another. Common symptoms included chest pains, a lump in the throat, difficulty swallowing (globus hystericus), aches and pains and shortness of breath, to name but a few. These are common symptoms that people with hypochondriasis still suffer from (Fallon, 2007). Unlike the current stigma of hypochondria (Maj et al, 2005), in ancient Greek times hysteria was seen as a purely medical condition occurring only in women. However it seems the etiology and treatment back then had much stigma also, highlighting the sexist nature of those times as much as the lack of anatomical understandings of the human body (Showalter, 1997).

2.1 The Wandering Womb:

The cause of hysterical symptoms was thought to be related to the woman's womb. The theory was that the woman's uterus somehow began to move to various parts of the body (Starcevic & Lipsitt, 2001). Therefore painful symptoms reported throughout the body were affected by this 'wandering womb'. Twenty-first century Western etiology for hypochondria is discussed in terms of typical age of onset and socio-cultural factors such as gender that may influence the disorder (Maddux & Winstead, 2008). For example, similar to many other mental illnesses, typical age of onset for hypochondria is late teens to early adulthood, with slightly more women reported as being affected (Sadock & Sadock, 2003). Similarly in ancient Greek times, there was talk about the illness afflicting *"young unmarried virgin women, and on occasion widows"* (Pilowsky, 1997,p.121). The societal context at the time would have been an underlying factor in differentiating our current definitions of age, as teenage years were not defined as they are now. The theory of the wandering womb concluded that the womb must be wandering in these young unmarried women and widows, to be seeking semen. The womb

therefore would settle once semen was found, and thus treatments consisted of finding hysterical patients husbands very quickly! Main treatment goals were marriage, intercourse and pregnancy (Shapiro & Rosenfeld, 1987).

Reflecting this oppressive nature in society is Aretaeus of Cappodocia's second century description of hysteria:

> In the middle of the flanks of women lies the womb, a female viscous, closely resembling an animal; for it is moved hither and thither in the flanks, also upward in direct line to below the cartilage of the thorax and also obliquely to right or left, either to the liver or spleen; and likewise is subject to prolapsus downwards, and, in a word, it is altogether erratic. It delights also in fragrant smells and advances towards them, and it has an aversion to foetid smells and flees from them and, on the whole the womb is like an animal within an animal *(Slaveney, 1990, p.13).*

It should be noted here that women are differentiated, in some way, from their wombs. It is not their wombs as part of them, but talked about as a separate object in this piece of writing, having a life of its own. While the '*husband search*' was on, the little animal inside the sufferer was lured back to its place via the vagina, with sweet smelling substances (perhaps administered by physicians) or repelled downwards by administering evil tasting and foul smelling substances (Showalter, 1997).

As well as typical objectification of that time, women were not allowed to inherit anything, were not to be educated as well as males, and, in financially secure families, were kept indoors, only making appearances in public places with a chaperone. Simon (1978) suggests that considering these women's inferior status and restrictive lives, hysterical behaviour might have been one of the few ways to express their dissatisfaction. Therefore these meanings mirror the culture of the time (sexism, power relations, women's roles and the lack of technology to have an understanding of physiological interactions in the body). However, what about male sufferers?

2.2 From Hysteria to Hypochondria - Men Become Included

Although traditionally thought of as a female ailment, conceptualizations were forced to change, as men persistently presented with symptoms of hysteria (Shapiro & Rosenfeld, 1987). This would have caused considerable conflict at the time, as men with hysteria must have impacted on the theory of cause, as well as treatment of hysteria (men not having wombs to wander about!). So much about hysteria was imbedded in the language and cultural constructs of that time, especially it being a female ailment. There may have been political implications for this gender label also, to keep women in place as married mothers. It appears, from the literature, that the theory behind hysteria was not ready to change very drastically. To incorporate males into the concept of hysteria was not possible, nor did it seem possible to change conceptualizations of hysteria into something larger to include both genders. Instead, existing views on hysteria continued and a separate but similar condition was reserved especially for the male sufferer of these same symptoms.

The word hypochondria, which came from the word *"hypochondruim"* was given to diagnose men (Maj et al, 2005; Pillowsky, 1997). Physiologically based in language like hysteria, Hippocrates used this word to describe the lower chest in front of the heart and the upper abdomen below the ribs (Starcevic & Lipsitt, 2001). In today's definition of hypochondria, the DSM-IV continues to refer to hysteria as the historical definition of hypochondria (American Psychiatric Association, 2000) and many authors have, over time, agreed that the two are actually the same (Fallon, 2007; Maj et al, 2005; Pilowsky, 1997; Showalter, 1997; Starcevic & Lipsitt, 2001). At this early stage in ancient Greece the medical conceptualization continued, but separated underlying causes by gender. As women would have hysteria, men would have hypochondruim pains and problems. Unlike women, men were not thought to have 'an animal inside an animal'. Their pains came from medical problems in the hypochondruim area. Thus men were not prescribed marriage, intercourse and pregnancy; in fact there was a lack of any treatment for men at this time. As hypochondria has been seen as resistant to treatment up until very recent times, perhaps this view began here. The ancient Greek view dominated understandings of hypochondria until the mid-sixteenth century.

2.3 Hypochondria as a Nervous Condition

In the mid-seventeenth century the concept of *'nervous disorder'* emerged. Thomas Willis (1621-1675) was the first person to conceptualize hysteria/hypochondria as involving the mind, rather than only physiological mechanisms originating in the womb and hypochondrium (Starcevic & Lipsitt, 2001). His quote illustrates this:

> *As we have shewn before that the passions vulgarly called hysterical do not always proceed from the womb, but often from the heads being affected: so though it has been vulgarly held that the effects called hypochondrical are caused by the most part by vapours arising from the spleen and running hither and thither; yet in truth those distempers are for the greatest part convultions and contractions of the nervous parts"* (Starcevic & Lipsitt,2001,p.9).

Willis' inclusion of the mind still took the purely physical form, but his was the first to extend beyond the long lasting typical conceptualizations, and it did sow the seeds for later mind/body discussions. As discussed, in ancient Greek times, the stigma of having hysteria was reflected in terms of gender. Symptoms were initially only diagnosed in women, treatment being marriage, intercourse and pregnancy. Behind this idea was that the hysterical patient *'just needed a man to make her better'* and her role of sexual object, wife and mother would correct her problems. However as more and more cases of males with bodily symptoms were being diagnosed, with the less stigmatized "hypochondriasis", scholars began to use the terms interchangeably. There was much agreement that the two labels were actually the one illness. This is reflected by narratives such as from Willis (1750) *"Since however much antiquity may have laid the blame of hysteria upon the uterus, hypochondriasis {which we impute to some obstruction of the spleen or viscera} is as like it, as one egg is to another"* (Starcevic & Lipsitt, 2001,p.156). With less use of the stigmatized word *"hysteria"*, the construct hypochondria, in time, became stigmatized itself.

Once known as an illness of medical gender based origin, the new label that encompassed both genders came under speculation as a feigned illness. This speculation still seems current today,

stigmatizing sufferers so much that many do not come forward to access help (discussed shortly). This controversy was first expressed in the writings of Sir Richard Blackmore (1729), physician to William III and Queen Anne. Blackmore argued:

> *Patients are unwilling their disease should go by its right name because the public regard their symptoms as an imaginary and fantastick sickness of the brain, filled with odd and irregular ideas. Such individuals often become an object of derision and contempt. However their sufferings are without doubt real and unfeigned* (Starcevic & Lipsitt, 2001, p.9).

Blackmore appeared to be a pioneer of his time. He may have provided the first narrative of a psychological meaning-making of hypochondria. In his work, *A Treatise of the Spleen and Vapours,* Blackmore rejected the past biological etiology, instead arguing: *"Terrible ideas, formed only in the imagination will affect the brain and the body with painful sensations".* He followed this theory by asserting that the hypochondriac's *"terrible imaginings"* physically affected the brain then body, thus hypochondria, he argued, was not a form of malingering or insanity (Starcevic & Lipsitt, 2001). Unfortunately much of Blackmore's advanced psychological explanations and defences against stigma fell on deaf ears. The next part of history continued the focus on biology, in *reflex theory* in the nineteenth to early twentieth century's.

2.4 Reflex Theory

Up until the early twentieth Century, reflex theory became a popular way of making sense of (mostly) female hypochondriacal suffering. According to this theory, every organ in the body could influence the other bodily organs (Shorter, 1992). The belief persisted that female hypochondriasis started with the uterus. However, reflex theory departed from ancient Greek views at this point; instead of the wandering womb going to organs and areas in the body, the womb used the spine as the 'go between', which then affected other organs in the body. Like the womb, the ovaries were also thought to be in contact with the spine and to irritate the rest

of the body. Here treatment of female patients consisted of applying pressure, often violently, to the ovaries. Clitoridectomy also became popular, as the clitoris was regarded as a potent source of reflex irritation. It is beyond the scope of this study to discuss at length the power relations and political issues involved in performing such operations on these women; however it does seem appropriate to mark the theme emerging of where the power resides in such relationships, notably in the medical profession. This treatment, as well as the occasional male circumcision, was reported in medical journals up until the outbreak of the world war in 1914 (Pilowsky, 1997). During this time period, the famous French physician Charcot added public humiliation to the list of treatments for sufferers.

2.5 Charcot - Theatrical Hysteria!

This section is thus titled because Charcot (1825-1893) headed a clinic in the Paris hospital, La Sapetriere, where he paraded hysterical patients on stage (Sternberg, 1999). Doctors from America and all over Europe came to France to watch these performances and patients came a great distance also. Said to be charismatic, Charcot had planned to be an artist before medical training, and had a studio in the hospital where he and his interns painted and sketched hysterical patients during their '*attacks*' (Shorter, 1997). Many of these paintings (mostly of women) were reproduced and sold, and a photographer was employed to increase this revenue as well. Two paintings were highly profitable - one was of a young woman named *Augustine.* The second was a picture of Charcot and his most famous patient *Blanche Wittman*, which hung in the lecture hall at the hospital. Even Freud had a copy in his office (Showalter, 1997), see figures 1 and 2.

Figure 1 – Augustine in a straitjacket

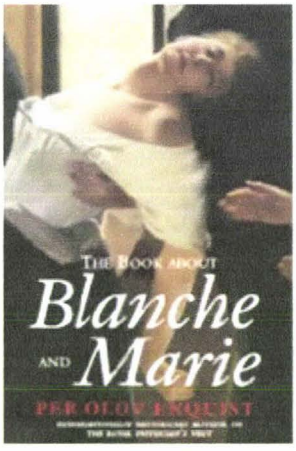

Figure 2 – Blanche and Charcot

Blanche Wittman's 'hysterical symptoms' started after an attempted rape. Likewise Augustine, the patient most photographed, reported that at age 13 she had been raped at knife-point, by her mother's lover, and soon after had hysterical symptoms. These included repetitive thoughts of being chased by a knife wielding man and experiencing pains. For these experiences she was treated with psychotropic drugs, straitjackets, solitary confinement, hypnosis and further objectification of having to frequently pose for photos and paintings. After five years in Charcot's hospital she eventually escaped by dressing up as a man (Showalter, 1997). Meanwhile Charcot continued on stage with his new patients.

Each week Charcot would publicly diagnose these women, without ever meeting them before the 'show'. The stage was set, including decorations and pictures applicable to each performance and according to his students, he often walked in with some distinguished guest at his side (Pilowsky, 1997). Charcot had a way of illustrating a point which often involved ridiculing his patients. For example, *"On one occasion, when he planned to discuss tremors, he brought in three women wearing hats with long feathers, each of which trembled in a way characteristic of its disease"* (Showalter, 1997, p.32). Furthermore, when he did do private consultations he had patients brought to his office, stripped naked, and then he would observe them. He would ask the patient to perform certain movements - stare, meditate, and then

have them led out, rarely exchanging words with them (Evans, 1990). According to Matlock (1994) these women were not consulted at all about their own bodies and symptoms. They were *"ridiculed, silenced, and reduced to storied bodies"* (Matlock, 1994, p.137). Charcot's methods were by today's standards completely unethical, and he may thus far look like a 'quack'. However it is worth noting today that in other roles he was a chief physician, who although his bedside manner may seem appalling, was responsible for differentiating multiple sclerosis from Parkinson's disease, and mapping out the spinal forms of Neuro-syphilis (Showalter, 1997). Charcot did shed some light on hysteria, which, until his time, was often not the focus of attention.

Charcot believed the causes of hysteria were biological. He believed hysteria to be due to either a hereditary defect, or a traumatic wound in the central nervous system that at times caused epileptiform attacks (Starcevic & Lipsitt, 2001). Charcot tended to move away from, and then come back to, the reflex theory of the times, as it waxed and waned in fashion. Therefore it is likely that his beliefs had their foundations in reflex theory, e.g. involving the spine/central nervous system. The epileptiform attacks resemble reflex theory in the general notion of the spine affecting other bodily organs. He further theorized that this genetic or traumatic nervous system dysfunction could be triggered by an emotional or physical trauma in vulnerable people. This then resulted in the different symptoms in patients' bodies that waxed and waned throughout their lives (Starcevic & Lipsitt, 2001). Also as in reflex theory, Charcot was interested in his patients' ovaries.

During autopsies on hysterical women, Charcot focused his attention on the ovaries, most probably looking to tie in the ovarian link with his spinal/central nervous system theory. When examining patients in general, he found ovarian sensitivity and as in reflex treatment, he applied pressure on patient's ovaries to initiate and stop attacks (Starcevic & Lipsitt, 2001). This can be likened to the old witch hunts of the past, where women were strapped to wooden trunks and then held under water for long periods of time. If they somehow survived they were proven witches, and dunked further. If they drowned then they were not! (Hicks & Gwynne, 1995). *'Damned if you do and damned if you don't'* logic must have applied to Charcot's

patients, as strangely enough pushing hard on these women's ovaries did bring on '*hysterical symptoms*'. Furthermore, in the end, if the only way to get Charcot to stop the painful pressure was to hold in their symptoms, many patients must have complied with this self-fulfilling prophecy.

Charcot provided details to his interns of how the hysterical patient's ovaries should be examined: *"It is indispensable to push on with the investigation, by penetrating in the abdomen with the fingers. The doctor should plunge his closed fist in the area of the ovarian pain"* (Evans, 1991, p29). Charcot's statement to his interns had plenty of seemingly sadistic and sexual undertones, with the usage of such terms as *push, plunge,* and *penetrate* (Showalter, 1997). Perhaps these relate again to the male dominated power and control in the history of medicine, and how that power relates to the construct of hysteria.

Foucault describes late nineteenth century medicine which played a part in constructing hysteria as follows:

> *(medical surveillance) was an enormous apparatus for observations, with its examinations, interrogations and experiments, but it was also a machinery for incitement, with its public presentations, its theatre of ritual crises, carefully staged with help of ether or amyl nitrate, its interplay of dialogues, palpations, laying on of hands and postures* (Foucault, 1978, p.55).

Unfortunately for his patients, Charcot took ovarian pressing further than reflex theory treatments by inventing the "Ovarian Compressor"! (Showalter, 1997), see Figure 3.

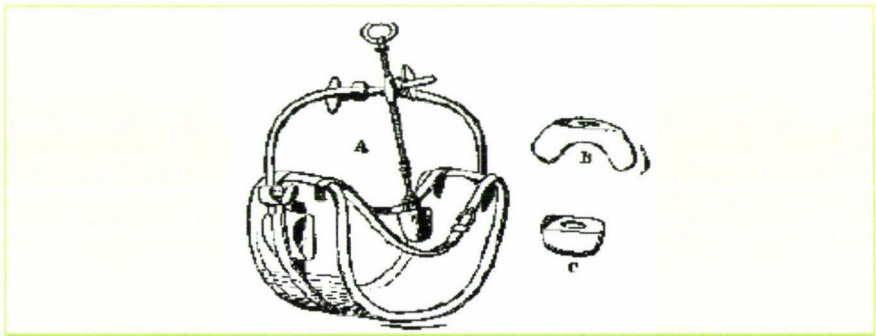

Figure 3 – Ovary Compressor as used by Charcot (Evan, 1991).

This tool was a heavy leather and metal belt which was strapped on to the patient and often left on for up to three days. In the few hypochondriacal men whom he treated, he compressed their testicles, which, not surprisingly, made symptoms worse (Showalter, 1997).

When Charcot died, so did many of his theories on hysteria. However his influence on hypochondria and health anxiety stigma can only be speculated. Research has shown a tendency for the medical profession to ridicule health anxious people although in present times nowhere near as blatantly as Charcot. Studies on doctors' perspectives of health anxious/hypochondriacal patients have reported the doctors' disparaging remarks, for example, labelling patients *'the worried well'* (Hayden & Brockmeier, 2008; Fraser & Greco, 2005; Persing, Stuart, Noyes & Happel, 2000). As the medical profession is ascribed much power in society, our current biases and ridiculing jokes about sufferers may have been impacted by Charcot's work. His teachings affected the course of many lives, one of which was a student at his hospital, Sigmund Freud.

2.6 Freud and the Talking Cure

Apart from Willis, who was ahead of his time, Freud was the first to truly deviate from basing hysteria, and interchangeably hypochondria, purely in biological terms. Freud had several revised theories on the subject, but generally he defined the condition as a neurosis that was caused by repression, sexuality issues and fantasy (Breuer, Freud, & Strachey, 1957).

After Charcot, Freud was influenced by his friend Dr Fleiss, who believed somatic symptoms were caused by excessive masturbation (Breuer, Freud & Strachey, 1957). Freud followed this doctor's theory that these sexual problems were due to a source in the nose, and allowed Dr Fliess to operate on his 27-year-old patient, Emma Eckstien. Dr Fleiss made serious errors during the nose operation, leaving gauze in the patient's nose which soon became infected. Freud argued that her post-operative symptoms (including haemorrhages) were merely

hysterical manifestations (Showalter, 1997). This example again illustrates the power of the medical profession, and the acceptance by society, of medical authority.

In *The History of Sexuality (*1978) Foucault wrote that women have been made into inert objects, for the power of medicine. Foucault argued that women's bodies were 'hystericalised', by the means of doctors turning patients' symptoms into a collection of psychological and physical symptoms.

Freud quickly revised the nose/masturbation theory. He later argued that all female hysteria and male hypochondria were due to a traumatic case history or life event. He applied to this his theories about defence mechanisms, such as repression, advocating that a traumatic event could be repressed, that is, that the memories of a traumatic event were then converted from consciousness into symbolic physical symptoms (Bernhiemer & Kahane, 1990). For example, a patient complaining of *globus hystericus* (tight throat, difficulty swallowing) might have converted the memory of being held around the neck, during a sexual assault. Later, in times of stress, the throat complaints and fixation and anxiety surrounding the throat may manifest but the sexual attack is blocked or repressed from memory. The converted trauma could be seen as a reflection of oppressive times for women in Freud's era. For example, one of Freud's patients, Anna O, was described by Breuer as *"very intelligent, with a quick grasp of things and a penetrating intuition, bubbling over with intellectual vitality"* (Breuer, Freud, & Strachey, 1957,p.217). Despite Anna's potential, she had led an extremely limited life within a very restricted family of origin. Under hypnosis, she regularly spoke of her memories, but also of her aspirations. During these conversations, her multiple physical symptoms would clear up. It was Anna herself who labelled Freud's therapy 'the talking cure' (Breuer, Freud, & Strachey, 1957).

While documenting his many case studies, Freud observed that the traumatic experiences of his patients centred on early childhood sexual abuse. In 1896, in a paper he addressed to the Viennese Society for Psychiatry and Neurology, he announced these views on the etiology of hysteria. He wrote *"At the bottom of every case of hysteria there are one or more occurrences of premature sexual experience, occurrences which belong to the earliest years of childhood"*

(Showalter, 1997, p.40). He called his theory the seduction theory. However, later, believing that so many cases of child abuse could not be so, he revised his theory again.

The new theory suggested that real traumas had actually not occurred, but instead desires from the unconscious and interrupted psycho-sexual phases were to blame. Such phases included the *Oedipus complex*, where young female children purportedly wish for sexual intercourse with their fathers (Sternberg, 1999**).** Feminist critics have pondered Freud's focus on the child's role in this complex and his lack of focus on the parents. Many feminists also criticized his theory revision in the first place (Bernheimer & Kahane, 1990; Fraser & Creco, 2005; Reiff, 1997; Schnurr & Green, 2004). This was especially so since Masson, then project director of the Freud archives, found many letters about sexual abuse of children and a pattern of omitting sexual abuse histories in later published case histories (Masson, 1984). According to Masson, Freud shifted the emphasis from an actual world experience of misery to an internal stage on which actors performed for an invisible audience. Freud was also said to have pressured patients into producing narratives that matched his revised etiological theory (Showalter, 1997).

Literature on the past language and stigma shows where some of our underlying beliefs and prejudices about health anxiety and hypochondria have stemmed from. This is related to entitlement of the sick role. The literature frequently suggests that the medical profession has some power in shaping views of this entitlement. History also highlights fluctuating doubt about whether symptoms are biologically or psychologically based. There has been, and still are, suspicions of malingering.

Although the term *hysteria* has been replaced by the more gender neutral *hypochondria*, the historical roots are evident in today's language. For example, even today we talk of slapping someone if they become so upset that they become hysterical 'to snap them out of it', reminiscent of pressing the ovaries. We now must take this understanding of historical background and stigma into more current etiology, treatment, definition and understanding of hypochondria and health anxiety. When discussing hypochondria from this point it is important

to keep in mind that the hysteria label has been dropped and hypochondria used to diagnose both genders now. In this thesis hypochondria and health anxiety will be used interchangeably.